Answers to Frequently Asked Questions
The Affordable Care Act in Illinois

To help us better respond to your questions about the Affordable Care Act as it relates to the Illinois Health Insurance Marketplace, Medicaid, Medicare, and related state programs, we will continually update this Answers to Frequently Asked Questions (FAQs). Please check the date on the bottom of the document to see when it was last updated.

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Illinois Health Insurance Marketplace

What is the Health Insurance Marketplace?

The Marketplace is a new way to find quality health coverage under the Affordable Care Act. It can help if you do not have coverage now or if you have it but want to look at other options. With one Marketplace application, you can learn if you can get lower costs based on your income, compare your coverage options side-by-side and enroll.

What is the name of the Marketplace in Illinois?

Get Covered Illinois is the name of the Illinois Marketplace website. You can go to www.GetCoveredIllinois.gov to: 1) get questions answered, 2) find specially trained counselors, called Assisters, near you to help you find and apply for the right coverage for you and your family and 3) answer a couple of screening questions so you can get to the right online application, either the Marketplace or Medicaid. If the answers to the screening questions guide someone to the Marketplace, they will go to the federally facilitated marketplace site since Illinois is a Partnership state and does not run its own Marketplace.

Can someone be denied health coverage through the Marketplace?

Most people who need health insurance will have the option of purchasing it on the Marketplace at full price. Only those who are not citizens and not lawfully present would be prevented from purchasing insurance on the Marketplace.

If a person applies for **financial assistance** through the Marketplace and the Marketplace decides they appear to be Medicaid eligible, the Marketplace will send them a notice of denial for premium assistance. That notice will indicate that they are likely eligible for Medicaid and that their application has been transferred to the state. Applicants have the right to appeal the Marketplace's decision even while their Medicaid application is pending. In addition, if someone has access to other minimum essential coverage like employer-provided coverage that is deemed affordable and adequate to the employee, they will not be eligible for financial assistance through the Marketplace.

Will the financial help to pay premiums come through tax credits?

Yes, on the Marketplace a new federal tax credit will be available to help individuals and families with incomes up to 400 percent of the federal poverty level purchase coverage on the Marketplace if they do not have an alternative source of minimum essential coverage (e.g., Medicaid, Medicare, etc.). These premium tax credits are advancable and will be available immediately upon enrollment so that families have the option to receive help paying their premiums every month rather than waiting until they file taxes. If the consumer chooses to take the tax credit in advance, the federal government will pay a share of the monthly health insurance premium directly to the insurer on behalf of the household.

For more information on how to estimate how much financial help may be available to someone, the Kaiser Family Foundation has developed a subsidy calculator which can be accessed at the following site: Kaiser Family Foundation subsidy calculator.

If someone receives an advancable tax credit through the Marketplace are they required to file taxes?

Yes, it is when you file taxes that the IRS makes sure that the amount of financial help based on projected income was appropriate based on the consumer's actual income. If the federal government paid too much in tax credits or subsidies, someone may owe the government some of that money back. If the federal government paid too little, it will refund what is owed to the individual. This is why it is critical to let the Marketplace know of any income changes throughout the year.

Are employees who cannot afford their employer offered health insurance able to receive a subsidy to help pay for their premiums?

Federal subsidies are only available for health coverage provided through the Marketplace. With respect to whether employees can drop their employer-sponsored coverage, the ACA is relatively specific on the circumstances in which employees with access to employer-sponsored insurance can receive subsidies. It depends on whether the employer-provided plans meet the affordability and adequacy standards set forth in the law.

If only employee coverage is offered:

- If the employee-only coverage offered is less than 9.5 percent of household income and the actuarial value of the plan is at least 60 percent, then the employee is considered to have access to alternative minimum essential coverage and will not qualify for financial help on the Marketplace. If the employee-only coverage offered is more than 9.5 percent of household income or the actuarial value of the plan is below 60 percent, then the employee is considered to *not* have access to alternative minimum essential coverage and may qualify for financial help on the Marketplace if household income is at or below 400% FPL.

If family coverage is offered:

- If the employee-only coverage offered is less than 9.5 percent of household income and the actuarial value of the plan is at least 60 percent, anyone in the family who has an offer of coverage from the employee, regardless of whether or not the family coverage is affordable, is considered to have access to alternative minimum essential coverage and will not qualify for financial help on the Marketplace. If the employee-only coverage offered is more than 9.5 percent of household income, then anyone in the family who is offered coverage is considered to *not* have access to alternative minimum essential coverage through the employer and may qualify for financial help on the Marketplace if household income is at or below 400% FPL and they have no other offer of minimum essential coverage.

If I am income-eligible for the Medicaid expansion, can I choose to buy a Marketplace plan instead? Will I get a subsidy?

All legal residents are eligible to buy a health plan through the Marketplace. However, if someone is eligible for Medicaid, they will not be eligible for any financial help through the Marketplace. That is

because Marketplace premium and cost-sharing subsidies are not provided to individuals who have access to other minimum essential coverage. Minimum essential coverage includes adequate and affordable employer-based coverage as well as Medicaid and Medicare.

If I am income-eligible for a subsidy, can I still get it if I want to buy private insurance instead of a Marketplace plan?

Marketplace plans are private insurance and many will be sold both on and off the Marketplace. Federal subsidies are only available to help reduce the costs of plans sold on the Marketplace.

If I am income-eligible for a subsidy, can I choose to enroll in a Platinum plan?

Yes, however, your premium tax credit will be based on the second lowest cost silver plan, so you may have to pay extra each month if you select a plan with a higher premium. Additionally, consumers eligible for cost-sharing reductions can only access them by enrolling in a silver level plan.

Will families be required to insure all members in the same Marketplace plan?

No, families may choose to buy different plans for different family members. Additionally, in some cases, children will be eligible for Medicaid through the All Kids program but their parents will not be because in Illinois the Medicaid/CHIP income threshold is higher for kids than it is for adults. In these cases, the adults will purchase coverage through the Marketplace with and the kids will enroll in All Kids.

Can my employer stop offering coverage and tell me to go to the Marketplace instead?

Yes.

If a legal immigrant has been in the United States less than five years, they do not have any income, are claimed as dependents by a relative on an income tax return, but are not eligible for job-related health insurance, what kind of health coverage can they apply for?

The individual who is not in the US for five years MAY apply on the Marketplace as a lawful resident. The only Medicaid benefit they may be eligible for is Emergency Medical services.

Even though they are the son's dependents they can still apply for Marketplace coverage under their own names. They'll be asked if they plan on filing taxes and answer no. Then, they'll be asked if they will be claimed as a dependent on someone else's federal income tax return and answer yes and that the tax filer is not seeking health insurance. They should be prepared to enter the tax filers SSN, which will be used to verify the household's income when checking for eligibility for financial help.

Will insurance brokers be selling both Marketplace and private insurance plans?

Generally yes, however, only agents and brokers who are registered with the Marketplace can help individuals and families find coverage and apply for financial help through the Marketplace. Registered agents and brokers can recommend specific health insurance plans for a family and business. Be sure to ask your agent or broker if they are registered to sell individual or small business plans with the

Marketplace. You can also click here http://getcoveredillinois.gov/get-help/ and use the links under agents and brokers to find an agent or broker near you.

Is there an enrollment fee for using the Marketplace?

No, there is no enrollment fee. In fact, it is expressly forbidden for consumers to be charged any fee by agents, brokers or Assisters for using the Marketplace. If someone claims that you will have to pay a fee for their help on the Marketplace, you should report them to the state by calling 866-311-1119.

Will staff in the billing departments of medical centers and hospitals be able to help with the Marketplace?

Only if they become certified Assisters through the Illinois Assister program. In general, hospitals and community health centers are applying to become Certified Application Counselors (CACs). CACs can hold themselves out as having been trained and certified by the federal government and state to assist consumers on the Marketplace. Staff is not required to become certified Assisters to help people apply for Medicaid through ABE.

If a child is on a Medicaid waiver, can a family still include him/her on a family Marketplace plan?

A child who is on a Medicaid waiver can be included on a Marketplace plan, however, the family will not receive any financial help in way of subsidies or tax credits to cover that child on the Marketplace health plan because Medicaid is considered minimum essential coverage. Individuals with access to minimum essential coverage are not eligible for financial help on the Marketplace.

If someone gets a subsidy for Marketplace coverage, can they still deduct medical expenses on their income tax return?

We do not anticipate qualifying for a premium tax credit impacting the deductibility of medical expenses, however, we cannot confirm that the IRS policy on deducting medical expenses will not change for tax year 2014. This IRS website only mentions deducting unreimbursed medical and dental expenses for 2013, but does not explicitly say this will no longer be an option for 2014. We have asked the IRS for clarification on this issue and will update this answer when more information is known.

When will the pre-existing condition disregard for adults end?

Starting in 2014, insurance companies cannot turn someone down or charge more because of a pre-existing condition. Because coverage for Marketplace plans do not begin until 2014, these rules are already applied when you shop on the Marketplace today.

For all plan years beginning in 2014, the plan cannot refuse to cover treatment for pre-existing conditions and coverage for the pre-existing condition begins immediately. This is true even if you have been turned down or refused coverage due to a pre-existing condition in the past.

The only exception is for grandfathered individual health plans that you buy yourself, not through an employer. They do not have to cover pre-existing conditions. If you have one of these plans you can

switch to a Marketplace plan during open enrollment and immediately get coverage for your pre-existing condition.

Will the prohibition on pre-existing conditions apply only to Marketplace plans, or also to privately-purchased insurance and to employment-based insurance?

The market reform setting standards for health insurance premium rating applies to private insurance plans both inside and outside the Marketplace in the individual and small group markets beginning in 2014. The Marketplace sells private insurance plans. The market reform does not apply to grandfathered plans, self-funded plans, excepted benefits, or individual short-term duration coverage. This market reform will apply in the large group market beginning in 2017 if the Marketplace begins selling plans to large groups at that time. However, it should be noted that pre-existing condition exclusions are not common in the large group market today.

Will all Marketplace plans have to cover all pre-existing conditions?

All Marketplace plans are required to offer, at a minimum, the ten categories of essential health benefits.

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (such as surgery)
- Maternity and newborn care (care before and after your baby is born)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Dental and vision services for children.

Plans may select the benefits that are offered within those categories as long as a minimum level of generosity within each category is met and may determine benefit administration rules as long as they are not discriminatory. If a benefit is covered under the health plan, the health plan cannot exclude coverage of that benefit for someone with a pre-existing condition or charge them more because of their preexisting condition. However, if the plan excludes a certain benefit, it is not required to add a benefit for a person with a pre-existing condition.

When will the Marketplace plans and rates be released?

Examples of Illinois' rates have been released and are available at healthcare.gov but do not include the subsidy calculations. A high level summary of Illinois rates can be found at:

- Illinois Qualified Health Plans Summary of Filed Plans (pdf)
- Illinois Rate Levels (pdf)

The employer penalty relates to an employee being charged more than 9.5% of income. Is that gross or net income? What reporting form does this information come from?

The employer penalty has been postponed for a year. It is possible there will be changes in approach subsequently. HHS did not finalize the employer shared responsibility rule after they delayed the mandate, but in the proposed rule (pdf), employers are allowed to use 9.5% of the employee's gross taxable wages reported in Box 1 of the W-2 form for that year to determine if they are in compliance.

Can the consumer stop and return to the account before hitting "submit?"

Yes, both ABE and the Marketplace permit applicants to save a partially completed application and return to it later. It is anticipated that consumers may not have all of the appropriate documentation at the time they apply. The system will allow consumers to add or correct information as necessary until they submit. At the time of submission and before leaving their ABE or Marketplace account, applicants will be able to upload documents to submit with their application.

What will be the process for paying the first month's premium?

As with the existing market, premiums will be due to the applicable insurer prior to a policy becoming effective. After the consumer selects a plan, they will be redirected to the issuer's website where they will receive premium payment instructions. The consumer will pay the premium directly to the issuer and must comply with the issuer's payment policies, which cannot be discriminatory.

- Typically, the cut-off date for initial premium payment will be the last possible date of plan selection for the coverage period (*e.g.,* December 15 for coverage beginning January 1).
- Issuers may allow individuals to make partial payments on the first month's premium, but should cancel coverage if a full payment is not made by the first date of coverage.

What is the time period before a person can decide to change plans if their current plan is effective?

Changing plans is only allowed during the open enrollment period and coverage for the new plan will not be immediately effective. If an individual makes a Qualified Health Plan (QHP) selection during the enrollment period, but later selects a new QHP before the coverage effective date, the initial QHP selection will be automatically cancelled. If any premiums were paid to the initial QHP, the issuer will be responsible for refunding the premium.

Are enrollees allowed to view all providers in the network through the marketplace website?

The Marketplace will provide a hyperlink to the issuer's website where the consumer can view in network providers before selecting and enrolling in a plan.

What happens to someone who misses open enrollment? Do they have to wait until the next open enrollment despite being required to purchase insurance?

Yes, unless they become eligible for a Special Enrollment Period due to a qualifying life event such as losing employer coverage or a change in family size.

If a prospective enrollee signs up AFTER December 15th, when will they be eligible for coverage?

The coverage start date depends on when you enroll in a health insurance plan. This chart below shows the coverage start dates based on enrollment dates. The consumer must make an initial premium payment for coverage to begin.

Health Insurance Plan Enrollment Date	Coverage Start Date
Oct. 1, 2013, through Dec.15, 2013	January 1, 2014
Dec. 16, 2013, through Jan. 15, 2014	Feb. 1, 2014
Jan. 16, 2014, through Feb. 15, 2014	March 1, 2014
Feb. 16, 2014, through March 15, 2014	April 1, 2014
March 16, 2014, through March 31, 2014	May 1, 2014

Is Illinois going to continue the ICHIP high-risk pool after January 2014?

Medicare carve-out plans and the federal Health Coverage Tax Credit (HCTC) will end on December 31, 2013. However, traditional plans 3 and W and HIPAA Plans 5 & X will not end on December 31, 2013. A specific notice will be sent to those enrolled in these plans should a decision be made to terminate coverage.

However, the ICHIP Board is encouraging all ICHIP members to explore their options and consider purchasing coverage through the Marketplace or through an insurance company because the coverage should be more reasonably priced with generally better coverage.

Click here for a list of frequently asked questions about ICHIP and the Affordable Care Act (pdf).

What should I do if I have COBRA?

COBRA is considered minimum essential coverage (Questions and Answers on the Individual Shared Responsibility Provision) so an individual with COBRA meets the requirement to carry health coverage. Anyone who is lawfully present can purchase coverage on the Marketplace at full price. Additionally, if the COBRA coverage is unaffordable (more than 9.5% of household income), the individual could choose to not enroll in the COBRA coverage and instead receive premium tax credits on the Marketplace (if 100-400% FPL). There is no waiting period.

What are some suggestions for providers to encourage people to enroll for coverage in light of the fact that most hospitals have Financial Assistance at the same levels or greater than what is available through enrollment in the Marketplace?

People need healthcare coverage for services other than hospital services. Indeed, waiting until health issues can only be addressed in a hospital contributes both to relatively high cost and relatively low quality of healthcare in America. There are also huge benefits to people from actually knowing they have insurance as opposed to relying on "charity" from hospitals.

Medicaid

How is Illinois Expanding Medicaid in January 2014?

The Affordable Care Act (ACA) made it possible for Illinois to expand Medicaid to adults ages 19 - 64 without dependent children and who are not disabled, we call this group "ACA Adults". Their income will need to be at or below 138% of the federal poverty level which is a monthly income of about $1,320/individual or $1,780/couple.

The ACA also expands Medicaid to former foster children through age 26 who were on Medicaid when they aged out of foster care. They are eligible regardless of income. This mirrors the ACA requirement that children be allowed to stay on their parent's private insurance coverage.

Is Medicaid coverage available for non-citizen children, or non-citizen parents, with family income above 138% federal poverty level?

Non-citizen children with family income up to 318% of the federal poverty level (FPL) may qualify for All Kids benefits. Non-citizens who do not qualify for Medicaid, and are lawfully residing in the U.S., may qualify for help to buy insurance on the Marketplace. Non-citizens who are not lawfully residing in the U.S. (undocumented) do not qualify for help to buy insurance on the Marketplace. Non-citizens who do not qualify for Medicaid solely due to their immigration status, may qualify for coverage of an emergency medical condition under the Medicaid Emergency Medical program only.

Do clients who are not citizens still have to give their taxes from the previous year to determine eligibility?

Applicants are not required to give tax information from a previous year to qualify for medical benefits. Eligibility is determined on current monthly income. Individuals who are not requesting benefits for themselves are not required to provide SSNs. However, proof of income is required from non-citizen parents whose income must be considered for their children's eligibility. Since the state will try to verify income electronically before asking the applicant to provide proof, the non-requestor is encouraged to provide their SSN if they have one.

For a Medicaid-only application in ABE, who should I include as living in the home?

Medicaid for children, families, and the expanded "ACA Adult" groups is now using Modified Adjusted Gross Income (MAGI) rules to calculate income and household size. **Therefore, the number of people you list as in your home is determined by those people about whom you should provide information. Who you should provide information about will depend on the situation. Attached is a grid of the information.**

Before starting an application in ABE, calculate the number of people in your home using the appropriate scenario below. The number of people in the home is the same number of people you should provide basic information about. However, specific information about social security numbers,

citizenship, and residency is only necessary for people applying for Medicaid coverage, not for people in the home who are not applying for Medicaid.

Scenario #1: If an applicant plans to file taxes for the current taxable year, they should include information about:

1) Any dependents, regardless of the dependents' age or relationship to the tax filer, who they plan to claim on their taxes; and
2) Their spouse, if they live together, whether or not they plan to file taxes jointly.

Scenario #2: If the applicant: a) expects to be claimed as a tax dependent; **and** b) is being claimed by a parent, stepparent or spouse, they should provide information for all individuals in the "tax household" including:

1) The person filing taxes and claiming them as a dependent;
2) Any other person being claimed as a dependent by the person filing taxes;
3) The spouse of the person filing taxes, if they are live with the person filing taxes.

Scenario #3: If the applicant: a) does not expect to file taxes; b) does not expect to be claimed as a tax dependent by a parent, stepparent or spouse; or c) does not know yet what their tax filing status will be, they should provide information about the following individuals who they plan to live with.

1) Their spouse
2) Their children/stepchildren under age 19.

Scenario #4: If the applicant is **under age 19** and: a) does not expect to file taxes; b) does not expect to be claimed as a tax dependent by a parent, stepparent or spouse; or c) does not know yet what their tax filing status will be, they should provide information about the following individuals **who they plan to live with**:

1) Their parents/stepparents
2) Their siblings/stepsiblings who are also under age 19
3) Their children/stepchildren
4) Their spouse

What if I rent a room or am staying in a room at someone's house, do I have to include them on my Medicaid application?

You only have to include someone on your Medicaid application if they are considered people in the home based on one of the scenarios above. If you are not related to them and are not connected to them as a tax-filer or tax dependent, you **do not** include them on your application.

How does someone know if they should apply to Medicaid or the Marketplace?

Start at www.GetCoveredIllinois.gov to see whether to apply for Medicaid through ABE or for private coverage through the Marketplace. Answering the screening questions on www.GetCoveredIllinois.gov

will be easy and will guide someone to the quickest route to qualify for assistance. Applicants who have questions or are uncomfortable with online processes can work with trained counselors, called Assisters. A list of Assisters, by zip code or county can be found under the **Get Help** tab of www.GetCoveredIllinois.gov. If someone does not have a computer, call the Get Covered Illinois help desk at 1-866-311-1119 for answers to questions and to get a list of Assisters.

What should someone do if they already have Medicaid. Medicaid is sometimes called All Kids, Family Care, Moms & Babies, medical assistance, medical care, or public aid?

If you are already on Medicaid, you do not need to do anything. You have health coverage.

If I am income-eligible for the Medicaid expansion, can I choose to buy a Marketplace plan instead? Will I get a subsidy?

All legal residents are eligible to buy a health plan through the Marketplace. However, if someone is eligible for Medicaid, they will not be eligible for any financial help through the Marketplace. That is because Marketplace premium and cost-sharing subsidies are not provided to individuals who have access to other minimum essential coverage. Minimum essential coverage includes good, affordable employer-based coverage as well as Medicaid and Medicare.

How Do I apply for Medicaid?

Anyone interested in applying for Medicaid, food stamps – known as SNAP, cash assistance or the Medicare Savings Program can apply online by going to the state's new online Application for Benefits Eligibility (ABE) at www.ABE.Illinois.gov or calling 1-800-843-6154. You can also go to your local Family Community Resource Center (FCRC) or print an application from and mail it in.

Will there be training available on using ABE?

HFS has posted guides for using ABE (pdf) and a guide for community partners (pdf). HFS also has a recorded webinar on how to use ABE.

Will the local DHS case workers still have to approve applications submitted through ABE?

Only state caseworkers can make eligibility determinations for Medicaid. DHS will have a central unit of caseworkers processing applications taken by phone; HFS will continue to process applications centrally for medical benefits and DHS Family Community Resource Center (FCRC) staff will process applications as they do today.

How long will HFS continue to accept old paper applications?

HFS will accept old paper applications for some time but strongly encourage using ABE whenever possible, or the new paper multi-benefit application. This is because there are new income and household rules under the Modified Adjusted Gross Income standards (MAGI). Submitting old applications will require the caseworkers to follow-up with the applicant, delaying the process.

What is CountyCare?

CountyCare is an early expansion of Medicaid for ACA Adults who live in Cook County. Adults in CountyCare can receive comprehensive healthcare services from the CountyCare network of hospitals, pharmacies, doctors, behavioral health providers, community health centers and other providers before January 1, 2014. The program is operated by the Cook County Health and Hospitals System. Eligible CountyCare adults can only enroll in CountyCare through a CountyCare Application Assister in person or by phone by calling 312-864-8200. They cannot enroll in CountyCare through ABE or a Marketplace Assister. More information can be found on Cook County Health and Hospitals Systems Website.

If I have CountyCare right now, do I have to reapply?

No. Effective midnight December 31, 2013, the CountyCare waiver that expanded coverage to low-income adults in Cook County will expire and the state will make administrative changes necessary for CountyCare enrollees to be automatically transitioned to the ACA Adult group established under Illinois' state Medicaid plan. Individuals who have applied for CountyCare enrollment should also not reapply.

What about Emergency Medicaid for undocumented individuals after January 1, 2014?

Emergency Medicaid will continue. People who meet all the criteria for eligibility as an ACA adult *except* that they do not have legal status to live in the U.S. will qualify for Medicaid coverage of services required to treat an emergency condition. Coverage of emergency services for ACA adults will parallel what is currently available for other eligible groups.

Will non-citizens that meet the income guidelines be able to apply for backdated coverage for a hospital bill? Will a client assessment unit review still be needed?

The current processes will continue unchanged. Individuals who do not have legal status in the U.S. must meet all other Medicaid eligibility criteria and DHS's Client Assessment Unit must find that the services received were necessary to treat an emergency condition. As is the case today, this coverage is only granted retroactively with the exception of coverage of labor and delivery.

Can hospitals presumptively enroll people in Medicaid?

Currently, the only people who may be determined presumptively eligible for Medicaid by anyone other than a state caseworker are pregnant women. Pregnant women may only be determined presumptively eligible by organizations that have applied to be a Medicaid Presumptive Eligibility (MPE) provider, have gone through the training and have a written agreement with HFS.

A hospital presumptive eligibility program (HPE) will begin in Illinois in February of 2014. HFS will share information about this option to hospitals later this year. In the meantime, hospitals should assist patients with completing a Medicaid application in our new ABE system.

What is MAGI and who does it Affect?

MAGI is short for Modified Adjusted Gross Income and is a new budget methodology used to determine how to count income and who to include in the eligibility determination group (EDG) for each applicant or recipient. Illinois is applying MAGI rules to individuals applying for Medicaid who are parents or other caretaker relatives, pregnant women, children and ACA Adults regardless of whether they apply through the Marketplace or to the state.

If the eligibility of Adult Medicaid is based on income, do applicants have to provide asset information either on ABE or on the paper application?

Yes, but only when they have responded to questions that indicate that they are elderly or disabled which means they are over 65, on Medicare, Social Security Income (SSI), in Long-Term Care or they need Long-Term Care and are not eligible for another program like a family health plan.

ABE should only request asset information if the applicant indicated they are elderly or disabled as described above.

Will Medicaid patients need to pick a primary care physician?

For the first part of 2014, after their eligibility has been determined, most people who qualify for Medicaid will need to pick a primary care provider or health plan. Later that year, HFS will roll-out mandatory enrollment in some type of coordinated care entity. More information on this process will be available at a later date.

If an applicant has health coverage through the Marketplace, when (or if) they must choose a health plan, their choice of primary care physicians will depend on the plan chosen. If individuals currently have a primary care provider or other providers they would like to keep, they are advised to check the health plan provider networks.

Will all facilities be mandated to take these new Medicaid patients?

The rules for treating Medicaid patients will not change as a result of the new enrollment process. Illinois Medicaid has an enrollment broker that will provide information to you as a Medicaid recipient and help you choose the best provider or health plan for you.

If my child is on a Medicaid waiver, can I still include him/her on a Marketplace plan for my family?

A child who is on a Medicaid waiver can be included on a Marketplace plan, however, the family will not receive any financial help in way of subsidies or tax credits to cover that child on the Marketplace health plan because Medicaid is considered minimum essential coverage. Individuals with access to minimum essential coverage are not eligible for financial help on the Marketplace.

If a patient incurs medical bills after January 1, 2014 and the marketplace determines they are eligible for financial help on the Marketplace since they are over income for Medicaid, is it possible to apply for those medical bills through the local FCRC office & request a backdate under the spend down program?

First, because coverage through the Marketplace can begin only prospectively, it is possible that some people may be able to obtain retroactive Medicaid coverage by spending down for months prior to the start of their health insurance coverage through the Marketplace. This would occur, however, only in the case of people with disabilities, or over age 65, or pregnant women, or children under age 19. Spenddown for parents and other caretaker relatives will no longer exist after January 1, 2014 and federal law does not extend the spenddown option to ACA adults.

Will low income Medicare patients automatically be signed up for Medicaid as a secondary payer?

No. Low income Medicare patients must submit an application for Medicaid coverage including assistance with paying Medicare Part B premiums, deductibles and cost sharing.

Will HFS still have TPL (Third Party Liability) options after January 1, 2014?

Except for children in families with income greater than 200% of poverty, people do not have to be uninsured to qualify for Medicaid.

Will uninsured people still be able to go to Federally Qualified Health Centers (FQHCs) if they are not eligible for Medicaid or for the Marketplace?

Yes, FQHCs will continue to provide health care to people who seek it. For a list of all FQHCs in Illinois, go to Illinois Primary Health Care Association (IPHCA) Website.

Can families/guardians of Disabled Adult Children enrolled in Medicaid purchase wrap-around coverage for them from either the Marketplace or from a private plan?

Families or guardians can purchase wrap-around coverage in the private health insurance market but the Illinois Health Insurance Marketplace does not sell wrap-around coverage.

Can adults on Medicaid purchase dental or podiatry coverage stand-alone plans from the Marketplace? When will Medicaid restore dental coverage to its program?

The Illinois Health Insurance Marketplace offers stand-alone pediatric and family dental coverage but only for those who purchase a health plan through the Marketplace, not for those on Medicaid. Dental coverage can only be restored in Medicaid if there is a change in law and an appropriation to cover the costs. There is no stand-alone podiatry coverage offered on the Marketplace.

Medicare

If I have Medicare, do I have to enroll in any new health coverage?

If you have Medicare, you are already covered. You do not have to buy more health coverage, and a Marketplace plan is not appropriate for you. There is one exception to this rule: If you are offered Medicare coverage, but you are responsible for paying a premium for Medicare Part A, you may be eligible to purchase a Marketplace plan with financial help if you choose not to enroll in Medicare. For more information on who is required to pay a premium for Medicare Part A, see Medicare Part A Costs.

The Marketplace does not sell Part D prescription drug plans, Medicare Advantage plans or Medigap coverage. If you have questions about your Medicare coverage or are looking for supplemental coverage for Medicare, please visit www.Medicare.gov, call 1-800-MEDICARE, or contact the Illinois Senior Health Insurance Program (SHIP) at (800) 548-9034.

- There are a few things that are important for Medicare beneficiaries, or soon-to-be Medicare beneficiaries, to be aware of:
- The Affordable Care Act has expanded preventive and wellness benefits to millions of people, including those on Medicare. These include yearly "Wellness" visits and coverage for many preventive tests and services – without paying a dollar out-of-pocket;
- The ACA has also helped save money for Medicare beneficiaries in the prescription drug coverage gap ("donut hole") with big discounts on covered generic and brand-name drugs;
- Medicare's Blue Button has been expanded to give you a better picture of your overall health by providing you with better access to your Medicare claims and personal health information; and
- Medicare beneficiaries may not be sold duplicative coverage. This means that if a person is on Medicare, it is illegal for an insurance carrier to sell a Marketplace plan to him or her.

Can individuals who have Medicare enroll in coverage through the Marketplace?

No, in fact it is illegal for any Health Plans on the Marketplace to sell a Qualified Health Plan (QHP) to a Medicare beneficiary because it would be considered duplicate coverage under the law. This prohibition does not apply in the Small Business Health Options Program (SHOP) market.

What should Agents and Brokers do to comply with this guidance?

Consistent with the longstanding prohibitions on the sale of duplicate coverage to Medicare beneficiaries, agents and brokers are prohibited from knowingly selling a Medicare beneficiary a Marketplace plan. Agents and brokers may wish to protect themselves by asking each applicant about Medicare status.

What do Medicare beneficiaries need to know about Medicare and the Marketplace?

Individuals with Medicare need to know that if they have Medicare, a Marketplace plan is not appropriate for them. If individuals are seeking supplemental coverage for their Medicare, and do not have retiree coverage, they should consult Medicare.gov about enrolling in a Medicare Advantage plan or purchasing a Medigap policy. In addition, the Illinois Senior Health Insurance Program (SHIP) can answer questions about Medicare. Call them at 1-800-548-9034 or go online to Illinois Department on Aging Senior Health Insurance Program Website.

Can Medicare beneficiaries whose employer purchases insurance coverage through the SHOP be enrolled in a SHOP Qualified Health Plan?

Yes, Medicare beneficiaries whose employer purchases SHOP coverage are treated the same as any other person with employer coverage. The prohibition against selling duplicate coverage to Medicare beneficiaries only applies to coverage sold by an Issuer to an individual. SHOP coverage is sold to the employer. For Medicare beneficiaries who have coverage based on their or a spouse's current employment and are enrolled in SHOP coverage, the Medicare Secondary Payer rules, which govern the coordination of benefits between Medicare and the employer coverage, apply to employers with at least 20 employees.

If someone is eligible for both Medicare and Medicaid and is in the Dual Eligibles Pilot, will the program initiate coordination of pharmaceutical Part D benefits?

Yes, the plans participating in the Illinois Medicare-Medicaid Alignment Initiative (MMAI) will also provide Part D benefits.

What happens if someone who is Dually Eligible for Medicare and Medicaid goes to see a medical provider who accepts their Medicare coverage, but declines to bill Medicaid for the balance?

Providers must enroll with the health plan participating in MMAI. The health plan will reimburse the provider for all services provided, pursuant to their contract, regardless of whether it is a Medicare or Medicaid service. In the FFS systems, a dual eligible is not responsible for the 20% Medicare co-insurance, regardless of whether the provider bills Medicaid for it.

Is there a list of providers, including specialists, who have agreed to accept patient's Medicare as well as Medicaid benefits?

Each Health Plan in the MMAI has their own list of providers participating in their plan. Call the Illinois Client Enrollment Services (CES) at 1-877-912-8880 or go to their website http://enrollhfs.illinois.gov

Justice Populations

How are eligible clients currently learning about and enrolling in Medicaid? Why/how will this process be different from current Medicaid application?

Processes in place today will largely continue, however, with a new more integrated online presence. Currently, people can apply for Medicaid online at www.ABE.Illinois.gov, by mail, or in person at DHS offices, found at www.DHS.State.Il.US . Many people receive assistance from a healthcare provider to apply or are assisted to get Medicaid when they seek SNAP (food stamp) benefits. The state also has a network of All Kids Application Agents in place now but they can only help children, their parents and pregnant women apply.

Assisters under the ACA will have a broader role and can help individuals apply for both the Marketplace and Medicaid. Lists of Assisters can be found at www.GetCoveredIllinois.gov.
Education and marketing is rolling out and ramping up in Illinois.
Applications for the new Medicaid coverage will differ from applications for disability-based coverage in two ways:

- First, eligibility for the new Medicaid coverage is based on income and citizenship/residency only, not medical disability status. Thus the process requires limited documentation, and far less than what is needed for disability-based Medicaid. The review process is less complex and takes less time.
- Second, the ACA requires that the application process for new coverage be supported by a modern IT system. As a result, Illinois' ABE portal will accept electronic signatures and allow documents to be uploaded and submitted with online applications.

Will there be a limited time for enrollment?

There is no time limit for enrollment in Medicaid. Enrollment for insurance coverage through the Marketplace, however, will generally be limited to annual open enrollment periods, unless someone qualifies for a Special Enrollment Period.

1. For the first year, open enrollment will run from October 1, 2013 to March 31, 2014, with coverage beginning January 1, 2014 for those who enroll in a plan by December 15, 2013.
2. In future years, open enrollment will run from October 15 to December 7. For example, for plan year 2015, you must enroll by December 7, 2014. There are "life event" exceptions, as in most insurance enrollment processes.

Is release from incarceration considered a Qualifying Life Event for the purpose of being eligible for a Special Enrollment Period in the Marketplace?

Yes, if a person is incarcerated, they will have 60 days after the time of release to apply for insurance coverage through the Marketplace if eligible.

What if a client has a family? Where do they enroll?

They can use the same online sites or in person assistance that are available for individuals. Illinois Children and parents or caregivers are eligible for Medicaid through the All Kids program.

What agency will monitor continued eligibility of those enrolled?

HFS and DHS as its partner handle Medicaid eligibility. As a Partnership Marketplace, the federal government will monitor eligibility and enrollment in Marketplace plans. Enrollment in insurance will be tracked as part of annual tax return filings.

Will there be a database to keep track of who has applied or is receiving benefits?

A database is and will be available for Medicaid. Note, Medicaid eligibility is based primarily on financial status. An individual does not have to be uninsured to qualify for Medicaid. In those instances where an insured person qualifies for Medicaid, Medicaid is secondary payer.
The federal government will also have a database of individuals on Marketplace plans that will be reconciled with issuers throughout the year. When consumers enrolled in private insurance through the Marketplace go to use their health insurance, the system will work as insurance works today. Individuals will be responsible for showing their insurance card as proof of insurance to the provider.

How will this information be transferred from probation to IDOC? (if clients have already applied or are already receiving benefits)

IDoC has access to Medicaid information currently. HFS is exploring the legal options for extending similar access to probation departments.

Consumers cannot be enrolled in a Marketplace plan while they are incarcerated; this will be verified as part of the application process. If a consumer on a Marketplace plan becomes incarcerated, the consumer must report this information to the Marketplace.

Can people apply as they approach their parole date?

Yes, for Medicaid.

For the Marketplace, they can work on the application but cannot submit it until they have been released because the current application asks for the applicant's current incarceration status and does not have a field for future incarceration release dates.

Are applicants required to go through a navigator or are they just made available to those who may need assistance?

There is no requirement to use a Navigator.

How much coaching would be needed to get a client through an application?

The level of facilitation in the eligibility and enrollment process may depend on literacy levels, reading comprehension skills, and if they apply online, how familiar they are with using the Internet. Familiarity with how private health insurance works may also be a factor when it comes to selecting a plan on the Marketplace.
In addition, it is helpful, but not required, for clients to have certain information in order to complete the application such as their social security number.

Once an individual is found eligible for Medicaid, how long is the eligibility period?

Eligibility must be reviewed at least annually.

What if client's circumstances change?

If a person's income changes they must report the change. They must also report address changes, changes in household size and if they move out of state.
Reporting changes in circumstances for consumers receiving financial help on the Marketplace is critical because the financial help is based on the household's projected income level. It will be reconciled as part of the tax filing process based on the actual income. For example, if the consumer receives more financial help throughout the year than they should have, they will have to pay the federal government back at tax time.

Is there a re-eligibility review?

Yes.

Will a person's family household income be the determining factor of eligibility or is it based upon a person's individual income?

Medicaid eligibility and Marketplace eligibility for financial assistance are based on household income and household size (federal poverty level).

What if they live with people that are not family members?
To determine whose income counts, first we determine whether anyone files taxes and if so, who they claim as dependents. Unrelated people living together will be treated individually unless they file taxes together.

Are Medicaid benefits terminated when clients are incarcerated? (prison or county jail).

Per federal guidelines, incarceration does not make a person ineligible for Medicaid BUT neither federal CMS nor HFS can pay for healthcare that is provided while a person is in custody. For that reason, Illinois law and policy provides that eligibility for incarcerated persons cannot be cancelled solely for that reason.

If so, are benefits reinstated upon notification of release?

Yes

What documentation is needed at the time of enrollment?

The state and federal government will first attempt to verify eligibility electronically.

How are things like citizenship and identity going to be verified?

The state has electronic sources for verifying most eligibility criteria. Key among these is having a Social Security Number (SSN). Except in very limited cases of emergencies, adults qualify for Medicaid only if they have a Social Security number or have applied for one. If caseworkers can verify electronically that the SSN is correct, they will not seek additional information. We encourage those working with people whose identity is questionable not to apply for them until you can identify them.

The federal government will also be verifying information through electronic sources, including communicating with the Department of Homeland Security, Social Security Administration, and Internal Revenue Service.

When applications are done over the phone or the internet, will documentation be sent in?

As described above, no documentation will be required if eligibility factors can be verified through electronic data matching. If information cannot be adequately verified electronically, a DHS caseworker will request that supporting documentation be mailed in.

Is probation responsible for determining income levels and provide proof?

The state only requires that anyone helping an applicant apply work in good faith to help the applicant provide accurate information. However, if the state cannot verify someone's eligibility and they do not respond to requests for documents, the application will be denied.

Is there an exchange website to direct potential participants to?

Yes, the Illinois Health Insurance Marketplace, (the new name for the exchange), is www.GetCoveredIllinois.gov. There is also a Marketplace Help Desk at 1-866-311-1119 that provides the same information as the website including screening questions to help someone

determine where to apply, either Medicaid or the Marketplace and lists of specially trained counselors to help someone in person.

Are there expectations for ACA age-appropriate clients under the jurisdiction of the juvenile court (ie. probation or juvenile detention) to enroll and access benefits?

Yes – the same restrictions concerning payment for services as described above apply here. In Illinois, someone who is age 18 or older can apply for coverage through the Marketplace. However, Illinois' All Kids program coverage children under Medicaid through age 18 so if someone is 18 years old and is eligible for All Kids, they will not be eligible for financial help through the Marketplace.

What are the scope and length of services under the "Essential Health Benefits" categories?

On the Medicaid side, the plan is to provide the same benefits that are available to current Medicaid clients, except for long term support services. However, we are still in discussion with the HHS as to whether that is acceptable. (It will most likely be the provision in 2014, but may be different subsequently.) Those services will be available as long as the person is eligible for Medicaid.
On the Marketplace, all plans must cover the 10 Essential Health Benefits areas, which are:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization
- Maternity and newborn care (care before and after your baby is born)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

While every plan must have benefits within each area, the specific services covered and the administration of the benefits will vary by plan.

What services are contained in the basic benefit package? Will mental health and substance abuse treatment be part of every plan? Will inpatient substance abuse treatment be covered?

To the extent they are currently covered by Medicaid on the Medicaid side. Regarding the specific, inpatient substance abuse treatment options are limited.
On the Marketplace, while every plan must have mental health benefits, exactly what services are covered will vary by plan as long as the richness of the benefits are equal or greater than the

selected benchmark plan (the BlueCross BlueSheild/BlueAdvantage small group plan). However, free preventive services provided by every plan include alcohol misuse screening and counseling and depression screening for adults. Additionally, state and federal mental health parity laws will continue to apply.

What if a judge orders a specific type or duration of treatment and it is not covered or available through a provider? Will Medicaid cover court-ordered treatment?

Yes, but only if: 1) the treatment is a covered Medicaid service; 2) the individual qualifies for Medicaid and cooperates with the enrollment process; and 3) the provider is enrolled with the state to provide Medicaid services.

What if the judge orders someone go to a treatment agency that is not a certified provider?
The state can only pay providers enrolled with the Medicaid program to provide services. Note also that Illinois will be enrolling most ACA Adults in one or more coordinated care entities beginning sometime in 2014.

Does Illinois probation have input into the basic benefit plan in order to meet the needs of justice-involved individuals?

The Medicaid plan for ACA Adults will be formalized in rule. Any member of the public can comment on rules proposed by state agencies during a mandatory 45-day public comment period. Note that HFS intends to include behavioral health services in the plan for covering ACA Adults.

Is Illinois creating the option to establish "health homes", a wholistic approach to medical and behavioral health services?

There will be some "health homes" in Illinois, but the extent depends on the extent of provider interest. In any event, Medicaid understands the importance of a continuum of care that includes behavioral health services and inclusion/coordination of such services will be required, whether it is under the "health home" label or otherwise.

Will treatment under Medicaid and the Marketplace plans include a continuum of care?

See above for Medicaid. Individuals enrolling in health plans through the Marketplace have the option of choosing from HMOs, PPOs and Fee-For-Service plans.

How is Illinois gearing up the behavioral health and substance abuse treatment system to accommodate the increase in demand for services?

On the Marketplace side, the plans must include adequate provider networks. The Illinois Department of Insurance reviewed network adequacy as part of the qualified health plan

recommendation process and will be monitoring this requirement, including through compliance reviews and consumer complaints.
On the Medicaid side, the Department of Human Services/Division of Alcoholism and Substance Abuse & Division of Mental Health have a process for providers to apply for Medicaid certification.

How much money is allocated for Illinois? Will some of the money be used to develop needed services?

Medicaid and insurance funds follow the individual through their care. There are no caps on Medicaid contracts for providers in the new coverage. There are no grants for service development, as has been the case in other circumstances in the past.
For information on initiatives being funded under the Affordable Care Act in Illinois, visit http://www2.illinois.gov/GOV/HEALTHCAREREFORM/Pages/HealthReformInitiatives.aspx

How will enrollees access treatment?

On the Marketplace side, the coverage will be private health insurance and enrollees will access treatment the same way they access it on private health insurance today. (Note: Incarcerated individuals cannot be enrolled in Marketplace plans).

The same is true for Medicaid beneficiaries. Medicaid managed care is expected to play a larger role over the next few years, so enrollees may also be required to access services through a managed care plan.
What is the time frame for agencies to become Medicaid certified? How do they become eligible?

Agencies seeking Medicaid certification for mental health and substance use disorder services should refer to the process for becoming an Alcoholism & Substance Treatment and Intervention Services Provider on the Illinois Department of Human Services website.

Could paying the penalty for not enrolling in health coverage be cheaper than the cost of the most inexpensive plan under the Marketplace?

Yes, but it depends on the individual – some people may receive such a large financial subsidy to help them lower the cost of a health plan through the Marketplace that they would have no or almost no premium for their plans and would also have very limited cost sharing. In addition, without a health plan, an individual will have to pay for any health care expenses out of pocket in addition to the penalty. This could be financially devastating, especially in cases of severe injury.

What are the penalties for those who decide not to have health coverage? How are the penalties collected? How will the federal government monitor who has paid their penalty, when applicable?

In 2014, the penalty per individual is $95 or 1% of income, whichever is higher. This will increase to $695 or 2.5% of income per person in 2016. The penalty is included in a person's tax filing and will be monitored by the IRS.

Will there be any liability for probation to report any Social Security fraud they may come across?

The Affordable Care Act does not change current fraud reporting rules for probation.

Will probation get resources or manpower to conduct outreach and enrollment? Is there grant money to assist with this?

The period to apply for grant money to be a Navigator or In-Person Counselor has passed, however an agency can still apply and receive training to conduct enrollment assistance as a Certified Application Counselor organization. The application can be found at http://marketplace.cms.gov/help-us/cac.html. Certified Application Counselor organizations may obtain funding to support their enrollment efforts through other avenues, including private dollars or other grant programs.

What is TASC's role with outreach and enrollment to ACA for justice populations?

TASC is providing assistance to its client populations in applying for coverage. TASC is also part of several community collaborative enrollment projects led by health departments and other human service agencies (IPC projects).

Would we be required to notify Medicaid if clients moved out of state?

The responsibility to notify Medicaid of these kinds of changes rests with the enrolled person.

How will this apply to clients under the age of 18? Do they have different options than adults?

Individuals must be at least 18 years old to apply for health coverage through the Marketplace for themselves and/or their family. Additionally, the All Kids income eligibility threshold is more generous than the adult income eligibility threshold. Individuals are only eligible for financial help on the Marketplace if they do not have access to alternative minimum essential coverage (All Kids is considered alternative minimum essential coverage).

Clients under the age of 18 may be eligible for coverage under All Kids if their family income is below the income eligibility limit. Information about Illinois' All Kids program can be found here: www.allkids.com.